UNITED STATES DISTRICT COURT

for the

Eastern District of New York

Francisco Suriel *Plaintiff* v. The Port Authority of New York and New Jersey, et al. *Defendant*	)	Civil Action No. 19 CV 3867 (PKC) (ST)

SUBPOENA TO TESTIFY AT A DEPOSITION IN A CIVIL ACTION

To: EMT Matthew Lindstadt - Jamaica Hospital

(Name of person to whom this subpoena is directed)

☑ Testimony: YOU ARE COMMANDED to appear at the time, date, and place set forth below to testify at a deposition to be taken in this civil action. If you are an organization, you must promptly confer in good faith with the party serving this subpoena about the following matters, or those set forth in an attachment, and you must designate one or more officers, directors, or managing agents, or designate other persons who consent to testify on your behalf about these matters: Any and all information relating to your medical evaluation and medical treatment of Franciso Suriel on August 6, 2018, including any reports associated with this treatment.

Place:	Date and Time:
Deposition to be completed via video with an emailed link.The deposition may be recorded including audio and video and will be before a certified court reporter.	04/08/2021 10:00 am

The deposition will be recorded by this method: Video and audio

☑ *Production:* You, or your representatives, must also bring with you to the deposition the following documents, electronically stored information, or objects, and must permit inspection, copying, testing, or sampling of the material: Any and all medical records relating to the medical evaluation and medical treatment of Franciso Suriel on August 6, 2018. A duly executed HIPAA-compliant authorization for these records is attached.

The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: 03/30/2021

CLERK OF COURT

OR

Signature of Clerk or Deputy Clerk	/s/ Kathleen Gill Miller *Attorney's signature*

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* Defendants Port Authority of New York and New Jersey, et al., who issues or requests this subpoena, are:

Kathleen Gill Miller,150 Greenwich Street, 24th Floor, New York, New York 10007, 646-784-5271, kmiller@panynj.gov

Notice to the person who issues or requests this subpoena

If this subpoena commands the production of documents, electronically stored information, or tangible things before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name **Francisco Suriel**	Date of Birth [redacted]	Social Security Number [redacted]
Patient Address: **217 52nd Street, #3, Brooklyn, New York 11220**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Jamaica Hospital Medical Center, Att: Medical Records 90-09 Vanwick Express, Jamaica, NY

8. Name and address of person(s) or category of person to whom this information will be sent:
Christopher Valleta, Esq., The Port Authority of NY & NJ, 4 WTC, 150 Greenwich Street, 24th FL, New York, New York 10007.

9(a). Specific information to be released:
☒ Medical Record from 8/6/2018 to 8/6/2018
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____ _____	Include: (Indicate by Initialing) ☐ **Alcohol/Drug Treatment** ☐ **Mental Health Information** ☐ **HIV-Related Information**

Authorization to Discuss Health Information
(b) ☐ By initializing here _____ (Initials) I authorize _____.
to discuss my health information with my attorney, or a governmental agency, listed here:
_____.
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☒ Other: **LITIGATION**	11. Date or event on which this authorization will expire: **END OF LITIGATION**
12. If not the patient, name of person signing form: Gabriel P. Harvis	13. Authority to sign on behalf of patient: **POWER OF ATTORNEY**

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 8/7/2020
Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

To Execute HIPAA Medical Record Authorization Forms Pursuant to NY Public Health Law Section 18(1)(G) as Amended 03/06/09

I Francisco M. Suriel

Of 217 52nd St. #3, Brooklyn, NY

Do hereby appoint: **ELEFTERAKIS, ELEFTERAKIS & PANEK, P.C.** with offices at **80 Pine Street, 38th Floor, New York, NY 10005**, my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute **HIPAA medical record authorization forms pursuant to NY Public Health Law Section 18 (1)(G) as amended 03/06/09. ELEFTERAKIS, ELEFTERAKIS & PANEK, P.C.** is also authorize to execute a written request for my health information under **NY Public Health Law Section 18.** This Power of Attorney may be revoked by me at any time. This Power of Attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives, and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof I have hereunto signed my name this 10th day of August 2018.

X _____

(Patient's Signature)

_____

Barry N. Fett, Esq.

(Attorney)

ACKNOWLEDGEMENT

State of New York)

County of NY)ss:

On this 10th day of August 2018 before me came the undersigned, personally appeared Francisco M. Suriel, personally known to be proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at NY, New York.

_____

Notary Public

JANICE Q. RODRIGUEZ
NOTARY PUBLIC-STATE OF NEW YORK
No. 01RO6301849
Qualified in Richmond County
My Commission Expires 04-28-2022